

		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0012955</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>PROPHETS RIVERVIEW</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2004</u> to <u>12/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>310 MOSHER DRIVE</u> <u>PROPHETSTOWN</u> <u>61277-1002</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>WHITESIDE</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>RAYE NAE NYLANDER</u> (Title) <u>VICE PRESIDENT OF FINANCIAL SERVICES, CFO</u>	
Telephone Number: <u>(815) 537-5175</u> Fax # <u>(815) 537-5175</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>	
IDPA ID Number: <u>45-0228055</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: _____			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code _____			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>ALETA CARLSON</u> Telephone Number: <u>(605) 362-3843</u>			

Facility Name & ID Number PROPHETS RIVERVIEW# 0012955 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>20</u>	Skilled (SNF)		<u>7,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)		<u>18,250</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>70</u>	TOTALS		<u>25,550</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,675</u>	<u>10,367</u>	<u>1,228</u>	<u>24,270</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,675</u>	<u>10,367</u>	<u>1,228</u>	<u>24,270</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.99%

D. How many bed-hold days during this year were paid by Public Aid?

7 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)OUTPATIENT THERAPYF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐I. On what date did you start providing long term care at this location?
Date started 9/20/1967

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	195,139	7,093	5,296	207,528		207,528	(150)	207,378		1
2	Food Purchase		137,822		137,822		137,822	(13,526)	124,296		2
3	Housekeeping	54,285	16,003		70,288		70,288	(300)	69,988		3
4	Laundry	46,772	11,734		58,506		58,506	(143)	58,363		4
5	Heat and Other Utilities			67,236	67,236		67,236	(4,457)	62,779		5
6	Maintenance	69,844	3,565	37,509	110,918		110,918	(1,215)	109,703		6
7	Other (specify):*			11,589	11,589		11,589	(469)	11,120		7
8	TOTAL General Services	366,040	176,217	121,630	663,887		663,887	(20,260)	643,627		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	995,332	109,157	12,770	1,117,259		1,117,259	(62,677)	1,054,582		10
10a	Therapy	7,534	1,499	68,141	77,174		77,174	(26,789)	50,385		10a
11	Activities	67,641	3,276	9,811	80,728		80,728	(1,361)	79,367		11
12	Social Services	30,412	122	869	31,403		31,403	(3)	31,400		12
13	Nurse Aide Training										13
14	Program Transportation			4,456	4,456		4,456		4,456		14
15	Other (specify):*	33,142			33,142		33,142		33,142		15
16	TOTAL Health Care and Programs	1,134,061	114,054	96,047	1,344,162		1,344,162	(90,830)	1,253,332		16
	C. General Administration										
17	Administrative	55,121		110,437	165,558		165,558	34,079	199,637		17
18	Directors Fees										18
19	Professional Services			4,697	4,697		4,697		4,697		19
20	Dues, Fees, Subscriptions & Promotions			10,665	10,665		10,665	(5,777)	4,888		20
21	Clerical & General Office Expenses	77,652	11,424	41,866	130,942		130,942	(14,890)	116,052		21
22	Employee Benefits & Payroll Taxes			327,536	327,536		327,536	11,030	338,566		22
23	Inservice Training & Education			9,682	9,682		9,682	(453)	9,229		23
24	Travel and Seminar			3,481	3,481		3,481		3,481		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			39,031	39,031		39,031	(402)	38,629		26
27	Other (specify):*										27
28	TOTAL General Administration	132,773	11,424	547,395	691,592		691,592	23,587	715,179		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,632,874	301,695	765,072	2,699,641		2,699,641	(87,503)	2,612,138		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			151,657	151,657		151,657		151,657			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,644	7,644		7,644		7,644			35
36	Other (specify):*											36
37	TOTAL Ownership			159,301	159,301		159,301		159,301			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		43	2,963	3,006		3,006	(3,006)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,351	38,351		38,351		38,351			42
43	Other (specify):*			3,906	3,906		3,906	(3,499)	407			43
44	TOTAL Special Cost Centers		43	45,220	45,263		45,263	(6,505)	38,758			44
45	GRAND TOTAL COST											
	(sum of lines 29, 37 & 44)	1,632,874	301,738	969,593	2,904,205		2,904,205	(94,008)	2,810,197			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(13,526)	2		4
5 Telephone, TV & Radio in Resident Rooms	(4,457)	5		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)	(1,633)	6		16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(5,777)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(110,991)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (136,384)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	44,707		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 44,707		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (91,677)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

PROPHETS RIVERVIEW

ID# 0012955

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line	Reference
1	Uniform Income	\$ (1,499)	21	1
2	Administration	(59)	21	2
3	Wanderguard	(2,208)	21	3
4	Resident Supplies	(469)	7	4
5	Telephone	(3)	21	5
6	Activity	(150)	11	6
7	Radio Service	(1,140)	11	7
8	Proclaim Offset	(20,372)	10	8
9	Deferred Maint Exp - 2004	435	6	9
10	Barber/Beauty Exp	(3,005)	40	10
11	Supplies - Res Dev	(1,138)	21	11
12	Newsletter - Res Dev	(71)	21	12
13	Staff Dev - Res Dev	(453)	23	13
14	C/Serv-Shared Emp	(11,841)	21	14
15	Therapy Offset - PT, OT, ST	(26,768)	10a	15
16	Purch Svc-Laboratory	(1,862)	43	16
17	Purch Svc-Radiology	(1,247)	43	17
18	Lab Fees	(390)	43	18
19	Glucose Offset	(1,343)	10	19
20	Prescr Drugs - Reimb	(35,077)	10	20
21	Supplies - IV Therapy - IV Sol	(1,444)	10	21
22	Pharm-Inoculations-Res	(887)	10	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(110,991)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROPHETS RIVERVIEW# 0012955

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,526)	0	0	0	0	0	0	0	0	0	0	(13,526)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,457)	0	0	0	0	0	0	0	0	0	0	(4,457)	5
6	Maintenance	(1,198)	0	0	0	0	0	0	0	0	0	0	(1,198)	6
7	Other (specify):*	(469)	0	0	0	0	0	0	0	0	0	0	(469)	7
8	TOTAL General Services	(19,650)	0	0	0	0	0	0	0	0	0	0	(19,650)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(59,123)	0	0	0	0	0	0	0	0	0	0	(59,123)	10
10a	Therapy	(26,768)	0	0	0	0	0	0	0	0	0	0	(26,768)	10a
11	Activities	(1,290)	0	0	0	0	0	0	0	0	0	0	(1,290)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(87,181)	0	0	0	0	0	0	0	0	0	0	(87,181)	16
	C. General Administration													
17	Administrative	0	34,079	0	0	0	0	0	0	0	0	0	34,079	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,777)	0	0	0	0	0	0	0	0	0	0	(5,777)	20
21	Clerical & General Office Expenses	(16,819)	0	0	0	0	0	0	0	0	0	0	(16,819)	21
22	Employee Benefits & Payroll Taxes	0	11,030	0	0	0	0	0	0	0	0	0	11,030	22
23	Inservice Training & Education	(453)	0	0	0	0	0	0	0	0	0	0	(453)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(402)	0	0	0	0	0	0	0	0	0	(402)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(23,049)	44,707	0	0	0	0	0	0	0	0	0	21,658	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(129,880)	44,707	0	0	0	0	0	0	0	0	0	(85,173)	29

Summary B

12/31/2004

12/31/2004

[illegible]

Facility Name & ID Number **PROPHETS RIVERVIEW**# **0012955**

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 ADM/ACCTG	\$ 110,437	THE EV LUTHERAN GOOD SAMARITAN SOCIETY	100.00%	\$ 144,516	\$ 34,079
2	V						
3	V	22 UNEMPLOYMENT	9,097			9,133	36
4	V						
5	V	22 WORKERS COMP	33,084			46,388	13,304
6	V						
7	V	26 INSURANCE	39,031			38,629	(402)
8	V						
9	V	22 HEALTH INS	133,174			130,864	(2,310)
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 324,823			\$ 369,530	\$ * 44,707

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PROPHETS RIVERVIEW** # **0012955** Report Period Beginning: **1/1/2004** Ending: **12/31/2004**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1			NON APPLICABLE						\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **PROPHETS RIVERVIEW**# **0012955** Report Period Beginning: **1/1/2004**Ending: **2/31/2004****VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		NO ALLOCATION NECESSARY			\$	\$			1
2									2
3		SEE REPORT ON ALLOWABLE CENTRAL OFFICE EXPENSES FOR THE YEAR ENDED DECEMBER 31, 2003							3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	NOT APPLICABLE						\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$					\$	9					
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$					\$	14					
15	TOTALS (line 9+line14)						\$	\$					\$	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **PROPHETS RIVERVIEW**# **0012955** Report Period Beginning: **1/1/2004** Ending: **12/31/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																												
1. Real Estate Tax accrual used on 2003 report.		\$	1																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																									
3. Under or (over) accrual (line 2 minus line 1).		\$	3																									
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																									
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1999</td><td>8</td></tr> <tr><td>2000</td><td>9</td></tr> <tr><td>2001</td><td>10</td></tr> <tr><td>2002</td><td>11</td></tr> <tr><td>2003</td><td>12</td></tr> </table>	1999	8	2000	9	2001	10	2002	11	2003	12	<table border="1"> <tr> <td></td> <td>FOR OHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2003 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2003 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1999	8																											
2000	9																											
2001	10																											
2002	11																											
2003	12																											
	FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2003 \$	13																										
14	PLUS APPEAL COST FROM LINE 5 \$	14																										
15	LESS REFUND FROM LINE 6 \$	15																										
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																										

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROPHETS RIVERVIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0012955

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

A. Square Feet:

B. General Construction Type:

Exterior

BRICK

Frame

Number of Stories

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

APARTMENTS - 4

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1966	\$ 15,000	1
2					2
3	TOTALS			\$ 15,000	3

Facility Name & ID Number **PROPHETS RIVERVIEW**# **0012955**

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1967	1967	\$ 347,119	\$ 8,678	40	\$ 8,678	\$	\$ 323,257
5									
6									
7									
8									
9	Improvement Type**								
10	Building	1973	1973	669	17	40	17		521
11		1974	1974	483	12	40	12		368
12		1975	1975	31,653	791	varies	791		23,740
13		1977	1977	4,676		20			4,676
14		1979	1979	7,265		20			7,265
15		1980	1980	2,114	9	varies	9		1,982
16		1981	1981	58,599	1,404	varies	1,404		35,062
17		1982	1982	8,455		varies			8,455
18		1983	1983	14,821		varies			14,821
19		1984	1984	8,772	309	varies	309		8,772
20		1985	1985	25,345	699	varies	699		25,208
21		1986	1986	7,033	15	varies	15		7,009
22		1987	1987	78,081	3,616	varies	3,616		67,580
23		1988	1988	48,071	1,127	varies	1,127		42,028
24		1989	1989	102,492	199	varies	199		102,405
25		1990	1990	922,005	41,759	varies	41,759		718,145
26		1991	1991	5,729	168	varies	168		5,436
27		1992	1992	24,955	535	varies	535		22,630
28		1993	1993	11,809	282	varies	282		10,062
29		1994	1994	45,574	973	varies	973		39,335
30		1995	1995	31,371	1,133	varies	1,133		25,990
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Floor Covering for Maint Room	1996	\$ 605	\$ 61	10	\$ 61	\$	\$ 545		37
38	Bath Cabinets for Resident	1996	784	39	20	39		353		38
39	Ceiling Tile	1996	496	50	10	50		446		39
40	FRP Board and Supplies for 200	1996	205	14	15	14		122		40
41	Replace Water Lines from Boile	1996	6,000	240	25	240		2,100		41
42	Sanitizing Room/1/2 Down Payment	1996	5,497	550	10	550		4,901		42
43	Install Kemlite in 200 Wing	1996	453	23	20	23		200		43
44	Counter Top,Dining Room	1996	365	18	20	18		158		44
45	Lavatory Water Closet Tank	1996	445	22	20	22		193		45
46	York A/C Unit for 300 Wing	1996	7,100	473	15	473		4,023		46
47	Isolation Valves on Circulation	1996	1,300	130	10	130		1,094		47
48	Remove & Replace Counter	1996	600	40	15	40		337		48
49	AL & Partner Sys Configuration	1996	8,646		6			8,226		49
50	Steel Fire Doors	1996	2,857	143	20	143		1,202		50
51	Air Compressor for Air Handler	1996	511		5			488		51
52	Install Windows & Screens	1996	420	28	15	28		233		52
53	Water System	1996	4,500	225	20	225		1,856		53
54	Six Birch Dorts	1997	590	39	15	39		308		54
55	Amplifier-Intercom	1997	618	62	10	62		479		55
56	12000 BTU's Goodman Air Conditioner	1997	378		5			378		56
57	Green Louvered Shutters	1997	475	47	10	47		364		57
58	Install New Booster Heater	1997	1,286	129	10	129		975		58
59	Replaced Motor Coupling	1997	1,559	156	10	156		1,182		59
60	Reconfigured Water Heat Loop	1997	1,800	180	10	180		1,365		60
61	18 Rooms/Closet Doors/Comple	1997	6,320	421	15	421		3,160		61
62	Outdoor Home Sign	1997	1,000	66	15	66		500		62
63	36" Door Frame Guards/Contact	1997	1,127	75	15	75		570		63
64	Outdoor Home Sign	1997	2,000	200	10	200		1,483		64
65	Remodel Bath/Clean & Soiled UT	1997	33,471	1,338	25	1,338		10,487		65
66	Plumbing-Remodel 100 Wing	1997	504	25	20	25		197		66
67	Cabinets	1998	858	57	15	57		386		67
68	Counter Tops	1998	2,326	155	15	155		1,046		68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,882,187	\$ 66,732		\$ 66,732	\$	\$ 1,544,104		70

**Improvement type must be detailed in order for the cost report to be considered complete

1/1/2004 Ending: 12/31/2004

****Improvement type must be detailed in order for the cost report to be considered complete**

1/1/2004 Ending: 12/31/2004

****Improvement type must be detailed in order for the cost report to be considered complete**

1/1/2004 Ending: 12/31/2004

****Improvement type must be detailed in order for the cost report to be considered complete**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,333,069	\$ 99,039		\$ 99,039	\$	\$ 1,705,079	1
2	Land Improvement Continued								2
3	1 Coat of Sealer To Parking Lot	1995	1,500		5			1,500	3
4	Gazebo & Preparation	1996	3,234	162	20	162		1,401	4
5	Remove Existing Payment	1997	7,843	392	20	392		2,908	5
6	Seal Coat Front Parking Lot	1997	2,500	250	10	250		1,854	6
7	Mulch Edging Fabric Weed	1998	582		5			582	7
8	Edging Pipedrain Elbow	1998	1,062	106	10	106		699	8
9	Gutter Screen Retaining Wall	1998	902	90	10	90		579	9
10	Perennial/Planting/Landscap	1999	1,726	156	10	156		794	10
11	Landscaping	2000	1,094	109	10	109		483	11
12	Parking Lot Overlay/Seal	2001	22,000	1,100	20	1,100		3,668	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,375,512	\$ 101,404		\$ 101,404	\$	\$ 1,719,547	34

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 487,189	\$ 48,018	\$ 48,018	\$		\$ 259,001	71
72	Current Year Purchases	17,301	1,666	1,666			1,666	72
73	Fully Depreciated Assets	280,037					280,037	73
74								74
75	TOTALS	\$ 784,527	\$ 49,684	\$ 49,684	\$		\$ 540,704	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Van and License	1992	\$ 35,985	\$	\$		4	\$ 35,985	76
77	Resident Care	1988 Cadillac Brougham	2000	3,510	585	585		4	3,510	77
78										78
79										79
80	TOTALS			\$ 39,495	\$ 585	\$ 585	\$		\$ 39,495	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,214,534	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,673	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 151,673	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,299,746	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments Unit 40	\$	\$	\$	86
87	Building	65,102	2,465	48,721	87
88	FFE	8,528	188	7,947	88
89					89
90					90
91	TOTALS	\$ 73,630	\$ 2,653	\$ 56,668	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 108,816	92
93			93
94			94
95		\$ 108,816	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **7,644**

Description: **Computer equip lease, Medical Supplies**

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2005 \$ _____

13. _____/2006 \$ _____

14. _____/2007 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		433	\$ 27,629	\$	433	\$ 27,629	1				
2	Licensed Speech and Language Development Therapist		hrs			104	3,220		104	3,220	2				
3	Licensed Recreational Therapist		hrs								3				
4	Licensed Physical Therapist		hrs			380	30,259		380	30,259	4				
5	Physician Care		visits								5				
6	Dental Care		visits								6				
7	Work Related Program		hrs								7				
8	Habilitation		hrs								8				
9	Pharmacy		# of prescripts								9				
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												
10	Academic Education		hrs								10				
11	Exceptional Care Program										11				
12											12				
13	Other (specify):										13				
14	TOTAL			\$		917	\$ 61,108	\$	917	\$ 61,108	14				

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 43,150	\$	1
2	Cash-Patient Deposits	4,767		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	291,877		3
4	Supply Inventory (priced at)	15,924		4
5	Short-Term Investments	973,803		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	103		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,329,624	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	2,363,810		14
15	Leasehold Improvements, at Historical Cost	76,803		15
16	Equipment, at Historical Cost	832,550		16
17	Accumulated Depreciation (book methods)	(2,356,414)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	65,570		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Asset Management Purch, CIP</u>	140,825		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,138,144	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,467,768	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 35,327	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,088		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,337		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Group Ins-emp Portion/Misc W/H</u>	(199)		36
37	<u>Security Dep - Apts</u>	4,134		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 195,687	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 195,687	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,272,081	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,467,768	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,268,939	1
2	Restatements (describe):		2
3	Dnr Rst Oper Gft-Cash	1,109	3
4	Net Income Unit 40 - Apartments	24,091	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,294,139	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	44,632	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Dnr Rst Prop Gft-cash	(18,950)	15
16	Other (describe) Cash Asset Assess-CO	(47,741)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (22,059)	17
	B. Transfers (Itemize):		
18	Rounding	1	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,272,081	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number PROPHETS RIVERVIEW

0012955

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,094,900	1
2	Discounts and Allowances for all Levels	(764,158)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,330,742	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	2,323	5
6	Therapy	274,365	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 276,688	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	601	12
13	Barber and Beauty Care	3,282	13
14	Non-Patient Meals	13,525	14
15	Telephone, Television and Radio	3	15
16	Rental of Facility Space		16
17	Sale of Drugs	80,507	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,795	19
20	Radiology and X-Ray	1,160	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 104,873	23
	D. Non-Operating Revenue		
24	Contributions	42,560	24
25	Interest and Other Investment Income***	112,777	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 155,337	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nsg & Medical Supplies	53,855	28
28a	Schedule Attached	27,332	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 81,187	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,948,827	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	663,887	31
32	Health Care	1,344,162	32
33	General Administration	691,592	33
	B. Capital Expense		
34	Ownership	159,301	34
	C. Ancillary Expense		
35	Special Cost Centers	45,263	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39	Rounding	(10)	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,904,195	40
41	Income before Income Taxes (line 30 minus line 40)**	44,632	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 44,632	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **PROPHETS RIVERVIEW**# **0012955**Report Period Beginning: **1/1/2004**Ending: **12/31/2004****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,280	1,396	\$ 30,133	\$ 21.59	1
2	Assistant Director of Nursing	612		14,356		2
3	Registered Nurses	7,229	9,081	159,437	17.56	3
4	Licensed Practical Nurses	12,728	14,404	222,694	15.46	4
5	Nurse Aides & Orderlies	53,908	57,834	545,954	9.44	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,747	2,110	25,405	12.04	9
10	Activity Assistants	4,955	5,546	42,710	7.70	10
11	Social Service Workers	1,847	2,053	30,491	14.85	11
12	Dietician					12
13	Food Service Supervisor	1,806	2,056	25,851	12.57	13
14	Head Cook	6,427	6,957	73,156	10.52	14
15	Cook Helpers/Assistants	10,007	11,452	95,654	8.35	15
16	Dishwashers	5	5	34	6.80	16
17	Maintenance Workers	5,091	5,514	68,505	12.42	17
18	Housekeepers	6,261	6,823	53,583	7.85	18
19	Laundry	5,657	5,582	45,961	8.23	19
20	Administrator	1,872	2,155	55,239	25.63	20
21	Assistant Administrator					21
22	Other Administrative	4,188	4,596	61,958	13.48	22
23	Office Manager	2,001	2,436	28,305	11.62	23
24	Clerical	1,946	2,159	20,863	9.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,823	2,033	23,730	11.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,390	144,192	\$ 1,624,019 *	\$ 11.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	137	\$ 4,529		35
36	Medical Director	24	3,000		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	81	1,805		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,543		44
45	Social Service Consultant	16	888		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	286	\$ 11,765		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number

PROPHETS RIVERVIEW

STATE OF ILLINOIS

0012955

Report Period Beginning:

1/1/2004

Page 21

Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeanette Soleta	Administrator	100	\$ 55,121
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,121

B. Administrative - Other

Description	Amount
Admin/Acctg	110,437
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 110,437

C. Professional Services

Vendor/Payee	Type	Amount
Evangelical Lutheran	MDCD Cost Report	800
Evangelical Lutheran	MDCR Cost Report	700
Berens & Tate PC	Legal Advise	3,078
James M Sweeney & Assoc	Document destruction	119
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 4,697

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 46,768
Unemployment Compensation Insurance	9,133
FICA Taxes	119,606
Employee Health Insurance	130,864
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Pension	28,776
Taxable Gifts	1,349
Admin/Consultant Savings	2,070
TOTAL (agree to Schedule V, line 22, col.8)	\$ 338,566

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	3,518
Health Care Worker Background Check (Indicate # of checks performed)	
Public Relations	2,214
Dues Reimb	4,032
Publications	902
Less: Public Relations	(2,214)
Less: Publications Reimbursable	(3,564)
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,888

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$ 3,038
In-State Travel	364
Seminar Expense	79
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 3,481

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Painting - 6 Restrooms	10/00	\$ 1,913	5	\$	\$	\$	\$ 381	\$ 287	\$	\$	\$	\$
2	Painting - Ceilings	2/01	51	5				10	10				
3	Painting	5/01	9	5				2	2				
4	Painting	6/01	8	5				2	1				
5	Painting	8/01	44	5				9	10				
6	Painting	8/01	31	5				6	8				
7	Painting	8/01	34	5				6	11				
8	Painting	9/01	48	5				9	16				
9	Painting	6/01	10	5				2	2				
10	Painting	9/01	17	5				4	3				
11	Painting	9/01	17	5				4	3				
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,182		\$	\$	\$	\$ 435	\$ 353	\$	\$	\$	\$

Facility Name & ID Number **PROPHETS RIVERVIEW**

STATE OF ILLINOIS

0012955

Report Period Beginning: **1/1/2004**

Page 23

Ending: **12/31/2004**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Netwrk \$3635
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,870 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 38,351
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 10,243
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 22%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: HENRY SCHOLTEN & CO The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.